

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08200

CERTIFICATE OF DEATH

08186

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oakland

c. LENGTH OF STAY IN lb

7 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Star Route 2 Box 82

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

June 14

Month Day Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

1/27/06

9. AGE (In years
last birthday)

61 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

e. IS RESIDENCE
ON A FARM?
YES NO 10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (County & State, or foreign country)

Underwood, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Seibert Ashby

14. MOTHER'S MAIDEN NAME

Rebecca Strawser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war dates of service]

no

16. SOCIAL SECURITY NO.

232-05-4136

17. INFORMANT

Mrs. Hazel Ashby see # 2 above Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Anemia Myocardial degeneration
Coronaria of lungs with metastasisINTERVAL BETWEEN
ONSET AND DEATH

3 days

1 yr

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 1920d. INJURY OCCURRED
While at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on June 7, 1967, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial23b. DATE THEREOF
6/16/67

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Gerald D. Minnick Oakland, Maryland

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Kitzmiller, MD

22b. DATE
SIGNED23d. LOCATION (City, town or county)
Garrett Co.

(State)

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 22 1967

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1922-1923

000230

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08201

CERTIFICATE OF DEATH

08187

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix two carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS Bowery St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Fannie		First	Middle	Lost	4. DATE OF DEATH Month June Doy 22 Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 86	9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Allegany, Md	
13. FATHER'S NAME John W. Blubaugh				14. MOTHER'S MAIDEN NAME Mary Alice Loar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Carl Bechie Loartown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ischemic heart disease (c) atherosclerosis					
INTERVAL BETWEEN ONSET AND DEATH ms					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) May (County) Tenn (State) 1967	
21. I certify that (I) (this hospital) attended the deceased from May , 1967, to Tenn , 1967, that (I) (we) last saw the deceased alive on 22 Jun 1967 and that death occurred at 8:25 PM , from causes and on the date stated above.					
22a. SIGNATURE B. L. Grant		22b. DATE SIGNED 23 Jun 67			
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 25 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Vale Summit Meth.	23d. LOCATION (City or Town) Alley (County) Md. (State)	
24. FUNERAL DIRECTOR Marion M. Sowers		ADDRESS Hafer-Sowers Funeral		25a. REC'D BY REGISTRAR Hom JUN 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
Marion M. Sowers		60 W. Main St. Frostburg, Md.			

5000

Area P

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08202

CERTIFICATE OF DEATH

08188

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY - Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland 4 days-7hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park 11/1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Bunaugh	Middle Lorida	Lost Month Day Year 4. DATE OF DEATH June 27, 1967	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH February 14, 1914--53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Prop.		10b. KIND OF BUSINESS OR INDUSTRY Nursing home	9. AGE (In years lost birthday) 53 yrs.	
13. FATHER'S NAME Charles		11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. MOTHER'S MAIDEN NAME Hart		Sarah Wilson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 220-32-4537	Address (Husband) Gorman Bowser, Deer Park, Md.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 <i>malignant melanoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>secrencea of urinary bladder</i> DUE TO (c) <i></i>		
		INTERVAL BETWEEN ONSET AND DEATH 3mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 25</u> , 1967, to <u>Jun 26</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 26, 1967</u> , and that death occurred at <u>12:58 AM</u> causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>B. L. Grant</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/27/67</u>
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 29, 67	23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery	23d. LOCATION (City or Town) (County) (State) Deer Park, Garr., Md.
24. FUNERAL DIRECTOR John O. Durst		ADDRESS <i>John O. Durst</i>	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
Leighton-Durst Funeral Home, Oakland, Md.			DATE JUN 30 1967	

211

1940-10-20 1940

6380

Identified

Amulet

Amulet

Amulet

Amulet

Amulet

Identified by Dr. H. G. Hart

Amulet

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

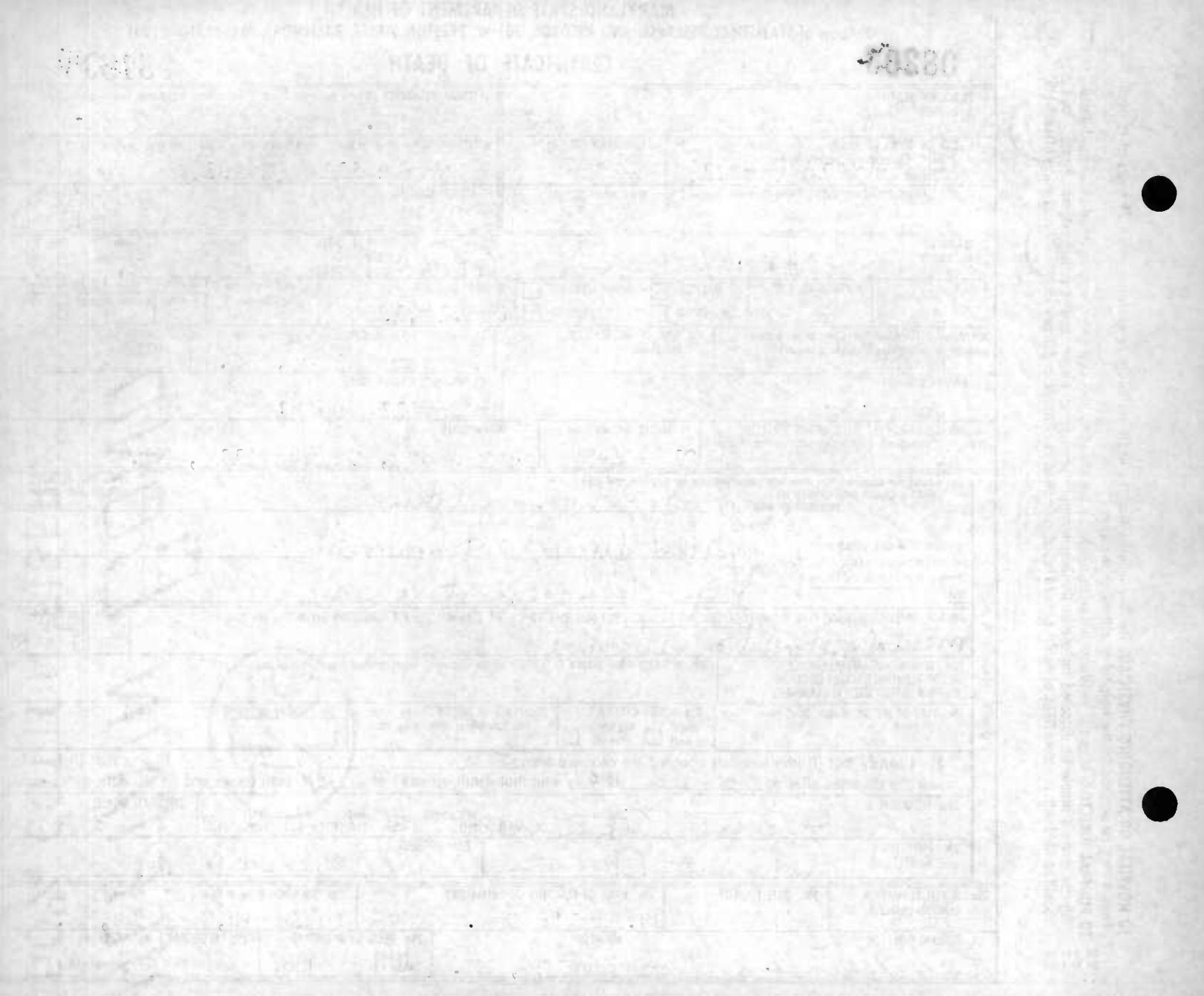
18
08203

CERTIFICATE OF DEATH

08189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville (Rural)		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		First —	Middle —
4. DATE OF DEATH Lost GEORG	Month June	Doy 1,	Year 19 67
5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 14, 1884
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Keyzers Ridge, Md.
13. FATHER'S NAME John Georg		14. MOTHER'S MAIDEN NAME Savilla Deihl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-56-7798	17. INFORMANT Address Ray Georg, Grantsville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) heart disease, arteriosclerotic DUE TO (c) Senile degenerative changes.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) mental retardation congenital		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 67 , to 6-1- , 19 67 , that (I) (we) last saw the deceased alive on 5-24 19 67 , and that death occurred at 2: P.M. , from causes and on the date stated above.			
22a. SIGNATURE Grant Atwell		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Grant Atwell		22d. ADDRESS Meyersdale, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/67	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cem.
24. FUNERAL DIRECTOR Ruth Newman		ADDRESS Grantsville, Md.	23d. LOCATION (City or Town) (County) (State) Accident, Garrett, Md.
VR A15 (4) 20 M 1/66		25a. REC'D BY REGISTRAR JUN 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08204

CERTIFICATE OF DEATH

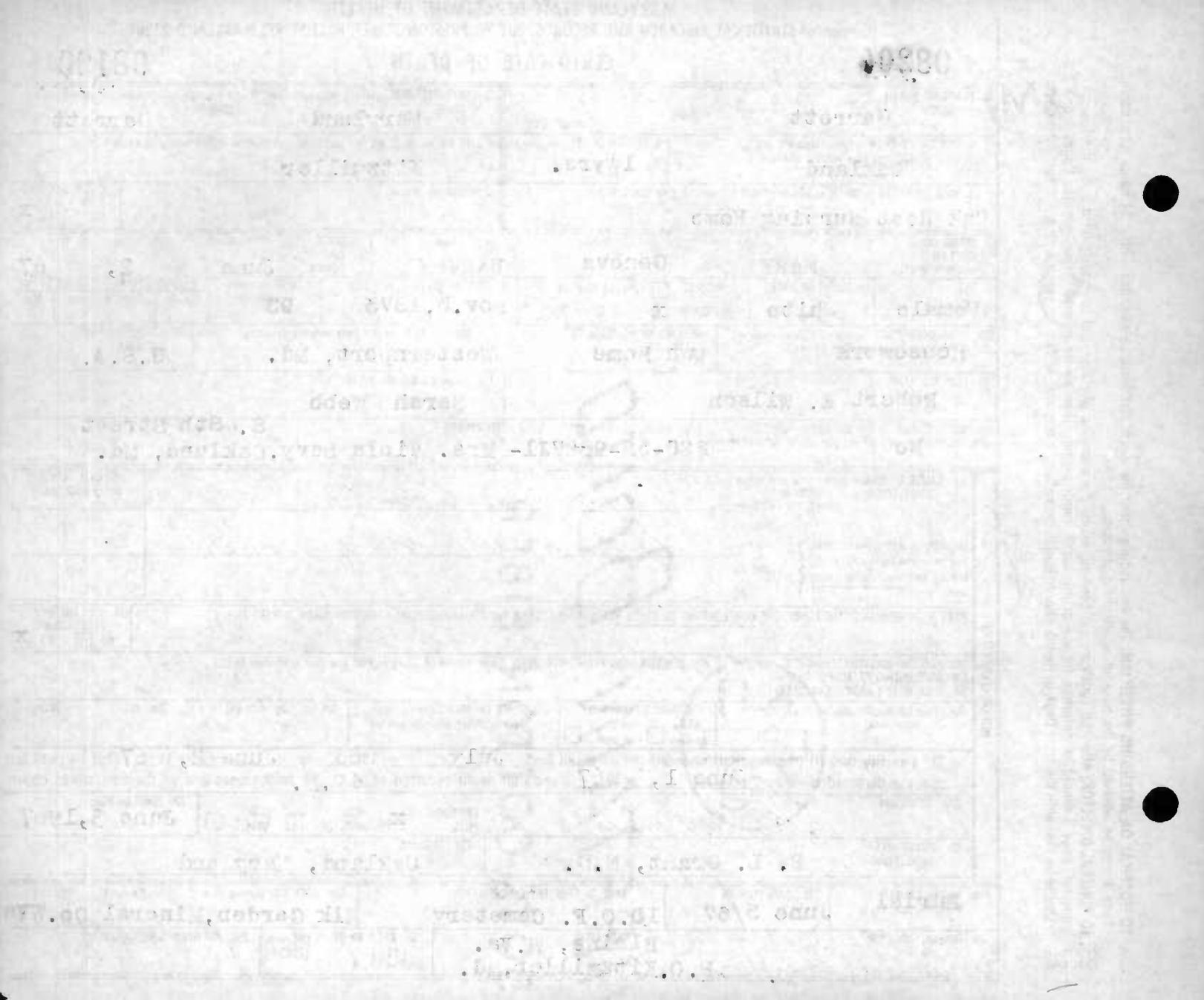
08190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1½ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Rest Nursing Home			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY		First Geneva	Middle 	Last HARVEY	4. DATE OF DEATH June 2, 1967	Month June	Day 2	Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1873	9. AGE (In years birthday) 93 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during working life. Check if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Westernport, Md.		
13. FATHER'S NAME Robert E. Wilson			14. MOTHER'S MAIDEN NAME Sarah Webb			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-52-9827J			17. INFORMANT S. Add 8th Street 1- Mrs. Viola Davy, Oakland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Ganglionic arteriosclerosis			DUE TO (b) DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to June 2, 1967 that (I) (we) last saw the deceased alive on June 1, 1967 , and that death occurred at 4 P.M. from causes and on the date stated above.								
22a. SIGNATURE B. L. Grant, M.D.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED June 3, 1967		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF June 5/67		23c. NAME OF CEMETERY OR CREMATORIAL I.D.O.F. Cemetery		23d. LOCATION (City or Town) (County) (State) Elk Garden, Mineral Co. W Va		
24. FUNERAL DIRECTOR Amy Mildred Shepherd, P.O. Kitzmiller, Md.			ADDRESS Blaine, W. Va.			25a. REC'D BY REGISTRAR DATE JUN 7 1967		25b. REGISTRAR'S SIGNATURE J



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08203

CERTIFICATE OF DEATH

08191

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 40 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 506 I STREET	
3. NAME OF DECEASED (Type or print) MARTHA		First ANN	Middle LAWTON
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public School		10b. KIND OF BUSINESS OR INDUSTRY TEACHER	
13. FATHER'S NAME OBED HAMPSTEAD		11. BIRTHPLACE (County & State, or foreign country) Preston Co., W. Va.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-38-5994	
17. INFORMANT H* PERCY LEE LAWTON-506 L STREET, MD.		Address MT. LAKE PARK,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 1914 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. Fibro-sarcoma, scalp		INTERVAL BETWEEN ONSET AND DEATH 11-6-62	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAKLAND, MARYLAND
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 6, 1962 , to JUNE 10 , 1967, that (I) (we) last saw the deceased alive on JUNE 10, 1967 , and that death occurred at 520 P , from causes and on the date stated above.			
22a. SIGNATURE J. Alvarez, M.D.		22b. DATE SIGNED 6/12/67	
22c. PHYSICIAN'S NAME (Type) DR. JOSEPH ALVAREZ		22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 13, 67	23c. NAME OF CEMETERY OR CREMATORIAL Garr. Co. Memorial Gar.
			23d. LOCATION (City or Town) (County) (State) Oakland, Maryland
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Leighton-Durst Funeral Home, Oakland, Ma.	25a. REC'D BY REGISTRAR JUN 14 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

64380

0071

Locality

Californian

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of either.

Page 4 may be retained by the hospital or attending physician.

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08206

CERTIFICATE OF DEATH

08192

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Fayette	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 2 Days 11½ Hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 16-Elm Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irene Marker		First Irene	Middle Marker	Last League	4. DATE OF DEATH June 4, 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-13-99		9. AGE (In years lost birthday) 67 yrs.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Brownsville, Pa.	
13. FATHER'S NAME Frank J. Marker		14. MOTHER'S MAIDEN NAME Nancy Coulter		12. CITIZEN OF WHAT COUNTRY? America	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT William League see # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH day	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. 4221		DUE TO (b) Anemosclerotic CV disease.			Yrs.
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Brownsville	(County) Pennsylvania (State)
21. I certify that (I) (this hospital) attended the deceased from July 6, 1967 , to June 4, 1967 , that (I) (we) last saw the deceased alive on June 4, 1967 , and that death occurred at 7:32A.M. from causes and on the date stated above.					
22a. SIGNATURE B. L. Grant		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5 Jun 67
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/7/67	23c. NAME OF CEMETERY OR CREMATORIAL Lafayette Mem. Park	23d. LOCATION (City or Town) Brownsville, Penna.	(County) Pennsylvania (State)
24. FUNERAL DIRECTOR: Gerald D. Minnich		ADDRESS Oakland, Maryland	25a. REC'D BY REGISTRAR DATE JUN 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.
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is necessary,
please execute
certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

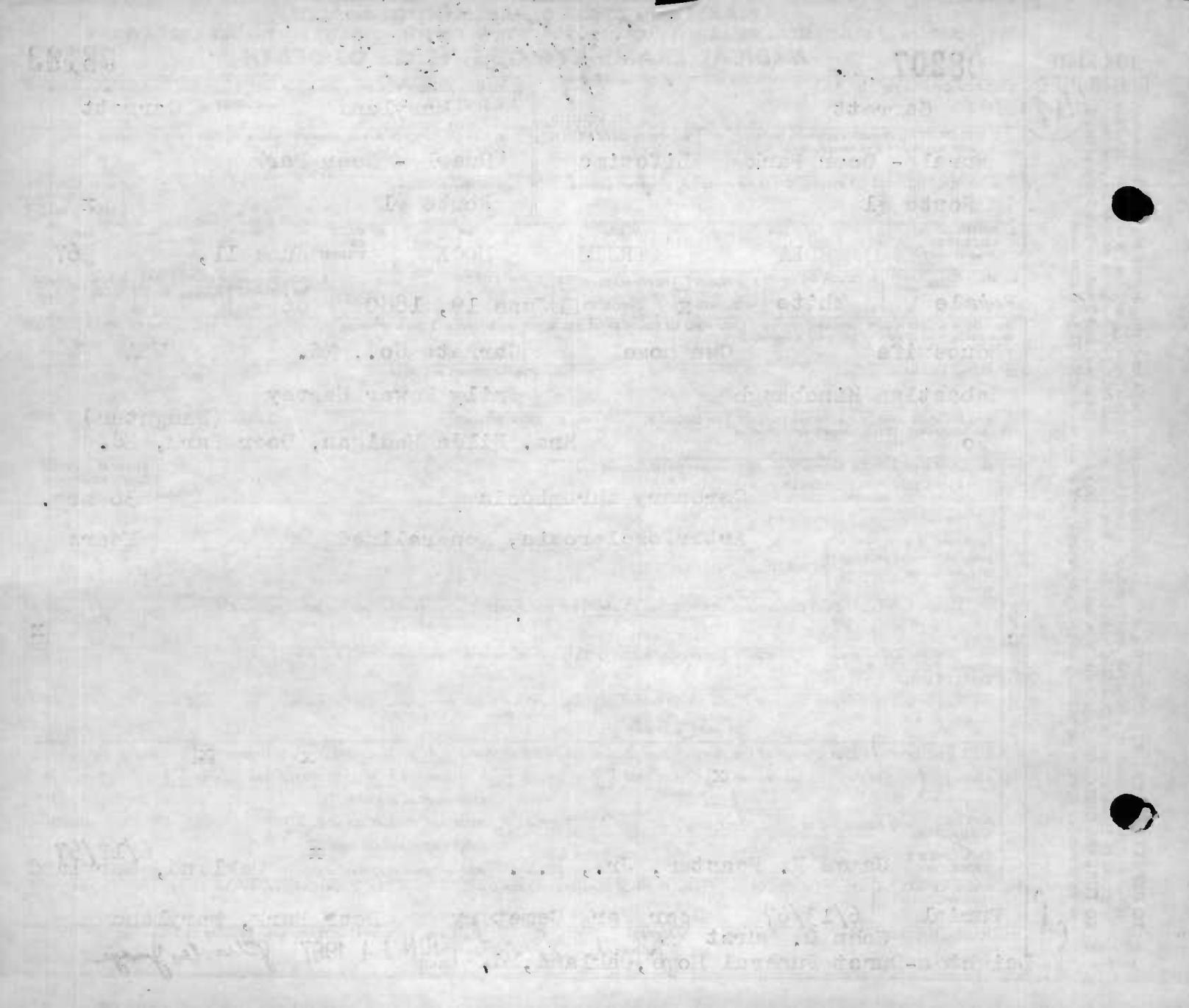
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08193

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Deer Park		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruarl - Deer Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #1		d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELLA	Middle TRUTH	Last MOON	4. DATE OF DEATH Month June Day 11 , Year 1967	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Last birthday June 19, 1880	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 0 Dey 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.	
13. FATHER'S NAME Sebastian Hinebaugh		14. MOTHER'S MAIDEN NAME Emily Tower Harvey		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war record or date of service)		17. INFORMANT Address (Daughter) Mrs. Hilda Madigan, Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis, generalized					
DUE TO (b) Arteriosclerosis, generalized					
DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 36 hrs.					
Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		2dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>					
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED 6/12/67					
Address (Street, city, town, or county) Oakland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/67		22c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery	
22d. LOCATION (City, town, or country) Deer Park, Maryland					
23. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.					
RECD BY REGISTRAR JUN 14 1967 24b. REGISTRAR'S SIGNATURE <i>Charles Juga</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

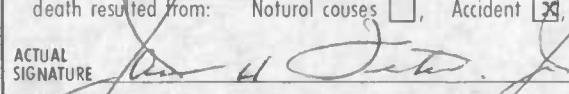
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08194

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Kentucky b. COUNTY Boyd	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN lb Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS 4023 Washington Ave.	
3. NAME OF DECEASED (Type or print) Thomas		First Richendollar	Middle Richendollar
4. DATE OF DEATH June 18 1967	Month June	Day 18	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 21, 1937	9. AGE (In years last birthday) 29 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Homer Richendollar	14. MOTHER'S MAIDEN NAME Irene Bleuins	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 407 48 2910	17. INFORMANT Patricia Richendollar, Ashland, Ky.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest; Crushed Face DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 81601 (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operating truck which wrecked and collided with car. Rt. 135	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:20 AM 6-18 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) Bloomington		(County) (State) Garrett Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED Oakland, Md. 6-18-67			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/67	23c. NAME OF CEMETERY OR CREMATORIAL E. Ashland Mem. Gardens
23d. LOCATION (City or Town) Ashland		(County) (State) Boyd Ky.	
24. FUNERAL DIRECTOR E.S. Boal Westernport, Md.		25a. ADDRESS ADDRESS	25b. REC'D BY REGISTRAR JUN 20 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Enthalpy

W/m² deg Celsius

1000

Temperature

Density

kg/m³

kg/m³

100

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0.005 0.01

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08195

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN 1b Minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piedmont
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 134 W. Fairview	
3. NAME OF DECEASED (Type or print) George		First Edward	Middle Riley, Jr.
4. DATE OF DEATH June 18th.	Month 1967	Day 1967	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Febr. 5, 1958	9. AGE (In years last birthday) 9 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY elementary school	11. BIRTHPLACE (State or foreign country) Keyser, W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Riley	14. MOTHER'S MAIDEN NAME Nellie Marie Hoover	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -	
16. SOCIAL SECURITY NO. - - -	17. INFORMANT George Riley	Address 134 W. Fairview, Piedmont	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull INTERVAL BETWEEN ONSET AND DEATH Sudden 8161 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (Passenger in auto struck by truck) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Passenger in auto which was struck by truck. Rt. 135	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:20 AM 6-18-67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Bloomington Garrett Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED Oakland, Md. 6-18-67
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Potomac Valley Mem. Gard.	23d. LOCATION (City or Town) (County) (State) Keyser, Mineral, W.Va.
24. FUNERAL DIRECTOR C. Boal	ADDRESS E. S. Boal, Westernport, Md.	25a. REC'D BY REGISTRAR JUN 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

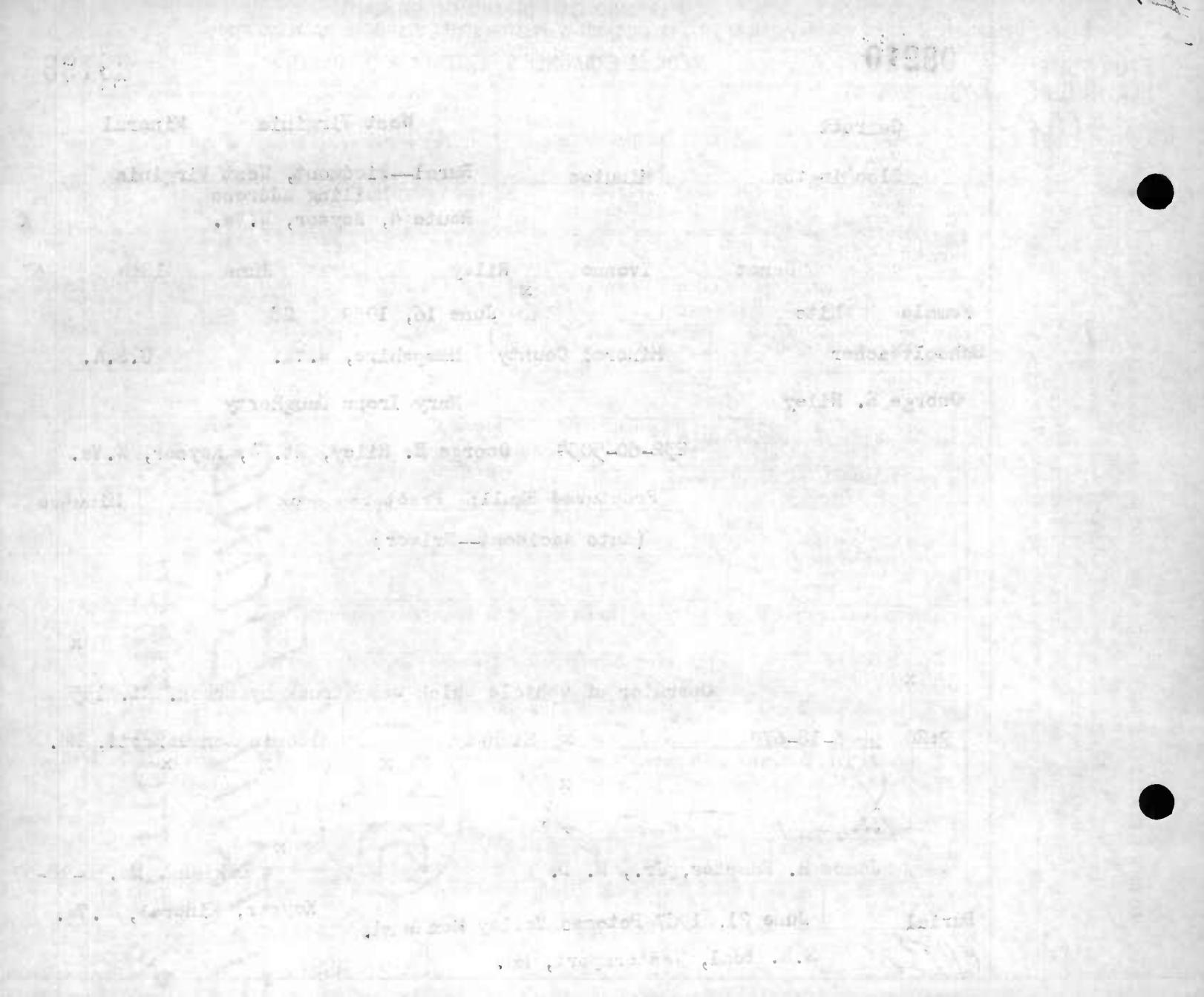
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08210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08196

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Piedmont, West Virginia	
		d. STREET ADDRESS Mailing address	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Route 4, Keyser, W.Va.	
3. NAME OF DECEASED (Type or print) Janet		First Yvonne	Middle Riley
3. NAME OF DECEASED (Type or print) Janet		4. DATE OF DEATH June 18th	Month 1967
3. NAME OF DECEASED (Type or print) Janet		5. SEX Female	6. COLOR OR RACE White
3. NAME OF DECEASED (Type or print) Janet		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1939
3. NAME OF DECEASED (Type or print) Janet		9. AGE (In years lost birthday) 28 yrs.	10. IF UNDER 1 YEAR Months 0
3. NAME OF DECEASED (Type or print) Janet		11. BIRTHPLACE (State or foreign country) Hampshire, W.Va.	12. IF UNDER 24 HRS. Days 0
3. NAME OF DECEASED (Type or print) Janet		13. FATHER'S NAME George E. Riley	14. MOTHER'S MAIDEN NAME Mary Irene Daugherty
3. NAME OF DECEASED (Type or print) Janet		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. 232-60-5054
3. NAME OF DECEASED (Type or print) Janet		17. INFORMANT George E. Riley, Rt. 4, Keyser, W.Va.	18. INTERVAL BETWEEN ONSET AND DEATH Minutes
3. NAME OF DECEASED (Type or print) Janet		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8/6/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	Fractured Skull; Fractured neck
3. NAME OF DECEASED (Type or print) Janet		DUE TO (b) DUE TO (c)	(Auto Accident--Driver)
3. NAME OF DECEASED (Type or print) Janet		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
3. NAME OF DECEASED (Type or print) Janet		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of vehicle which was struck by truck. Rt. 135
3. NAME OF DECEASED (Type or print) Janet		20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:20 AM 6-18-67¹⁹	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Janet		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Bloomington Garrett, Md.
3. NAME OF DECEASED (Type or print) Janet		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	22. DATE SIGNED James H. Feaster, Jr., M.D.
3. NAME OF DECEASED (Type or print) Janet		ACTUAL SIGNATURE 	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Janet		EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.	Address (Street, city, town, or county) Oakland, Md. 6-18-67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Potomac Valley Mem. Card.
24. FUNERAL DIRECTOR 		ADDRESS E.S. Boal, Westernport, Md.	25d. DATE JUN 20 1967
24. FUNERAL DIRECTOR 		25e. REG'D. BY REGISTRAR Charles J. ...	25b. REGISTRAR'S SIGNATURE



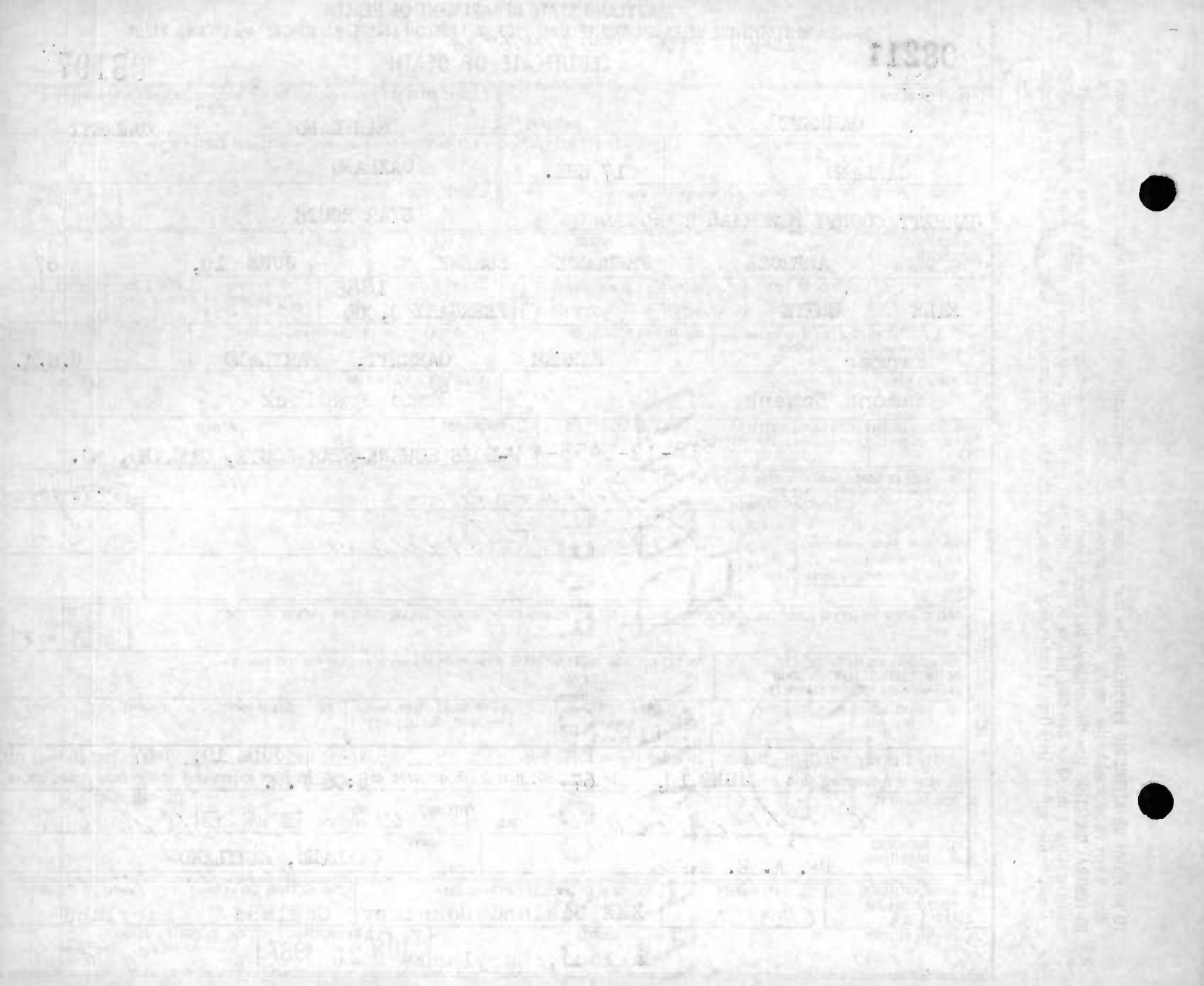
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08211

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G390 6/26/67 pc

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. LENGTH OF STAY IN lb 17 HRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			b. COUNTY GARRETT		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL						d. STREET ADDRESS STAR ROUTE					
3. NAME OF DECEASED (Type or print)		First AMBROSE	Middle FREDLOCK	Last SCHENK	4. DATE OF DEATH Month JUNE 10,	Month 19 67	Day	Year			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH FEBRUARY 3, 1885	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY FARMER			11. BIRTHPLACE (County & State, or foreign country) GARRETT, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Namond Schenk						14. MOTHER'S MAIDEN NAME Emma Fredlock					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 318-12-5453-4		17. INFORMANT W-LOIS SCHENK-STAR ROUTE, OAKLAND, MD.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterial sclerosis DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) OAKLAND		(County) MARYLAND		(State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 19 65 , to JUNE 10, 1967 , that (I) (we) last saw the deceased alive on JUNE 10, 1967 , and that death occurred at 8:06 P.M. from causes and on the date stated above.											
22a. SIGNATURE A. E. Mance						22b. DATE SIGNED 10 Jun 67					
22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE						22d. ADDRESS OAKLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/13/67		23c. NAME OF CEMETERY OR CREMATORIAL XXX Oakland Cemetery		23d. LOCATION (City or Town) Oakland		(County) Maryland		(State) MD.	
24. FUNERAL DIRECTOR Gerald D. Minich						ADDRESS Oakland, Maryland					
						25a. REC'D BY REGISTRAR JUN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20 M 1/66											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08198

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		c. LENGTH OF STAY IN lb 20 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 310 "E" Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EARL JOSEPH SEBOLD		First JOSEPH	Middle SEBOLD
4. DATE OF DEATH June 23 1967	Month June	Doy 235	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1911
9. AGE (In years at birthday) 56 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Road Building	11. BIRTHPLACE (State or foreign country) Garrett Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Joseph F. Sebold		
14. MOTHER'S MAIDEN NAME Elizabeth McGettigan	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. 219-14-5953	17. INFORMANT Lena Sebold, Mt. Lake Park, Md.	Address (Widow)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 9731 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran motor of car in closed garage while in back seat.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 10 xx 6-23-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State) Mt. Lake Park Garrett Md.	
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Garr. Md.	
22. DATE SIGNED 6-23-67		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/67	23c. NAME OF CEMETERY OR CREMATORIAL Garr. Co. Memorial Gard.
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Deighton-Durst Funeral Home, Oakland, Md.	25a. REC'D BY REGISTRAR DATE JUN 26 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

90000

НУЖНО ВЫПОЛНИТЬ КАКИЕ-НИБУДЬ

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08213

CERTIFICATE OF DEATH

08199

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
o. COUNTY Garrett MARYLAND				a. STATE Maryland b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 3 Days 13 Hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		d. STREET ADDRESS Rt. 1, Box 405		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary Elizabeth Sines		First	Middle	Last	4. DATE OF DEATH June 20 1967	Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-02	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Oakland, Maryland		
13. FATHER'S NAME Adolphus William Kimmell			14. MOTHER'S MAIDEN NAME Effie Roxanna Welch			12. CITIZEN OF WHAT COUNTRY? America		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-12-5453			17. INFORMANT A Address Clyde C. Sines see # 2 above		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Metastatic carcinoma</i>. DUE TO 159X INTERVAL BETWEEN ONSET AND DEATH 3 mo. Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <i>cancerous of pancreas.</i> DUE TO unk. (c) <i>unk.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland (County) Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 1963 , to June 20 1967 , that (I) (we) last saw the deceased alive on June 20 1967 , and that death occurred at 1:00AM , from causes and on the date stated above.								
22. SIGNATURE B. L. Grant								
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant			22d. ADDRESS Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oakland Cemetery		23d. LOCATION (City or Town) Oakland (County) Maryland (State)		
24. FUNERAL DIRECTOR Gerald D. Minich		25a. REG'D BY REGISTRAR JUN 26 1967			25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08214

CERTIFICATE OF DEATH

08200

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence & Commission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller		c. LENGTH OF STAY IN 1b 13 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First George	Middle William	Last T. Stewart	4. DATE OF DEATH Month June Day 8 Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1903	9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lemuel George W. Stewart	14. MOTHER'S MAIDEN NAME Rosetta Margaret Harvey			Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 233-16-5058	17. INFORMANT Gladys Stewart, Kitzmiller, Md. 21538	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Connie Hawkins</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Connie Hunt Deanna</i> DUE TO (c) <i>Diabetes Mellitus</i>	
				INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 5</i> , 1967, to <i>June 8</i> , 1967, that (I) (we) last saw the deceased alive on <i>June 5</i> , 1967, and that death occurred at <i>3:40 A.M.</i> from the causes and on the date stated above.				
22e. SIGNATURE <i>Ralph Calandrella</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D.		22d. ADDRESS Kitzmiller, Md. 21538		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 67	23c. NAME OF CEMETERY OR CREMATORIAL I.O.O.F. Cemetery	23d. LOCATION (City, town or county) (State) Elk Garden, Mineral C.W.Va.
24. FUNERAL DIRECTOR'S SIGNATURE <i>Amy Mildred Sharpless</i>		Bethel, W.Va. P.O. Kitzmiller, Md. 21538	25a. REC'D BY REGISTRAR DUN 12 1967	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>

1583

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08215

CERTIFICATE OF DEATH

08201

1
M
1. PLACE OF DEATH
e. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bloomington

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
JuneDay
28Year
1967

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

1865

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

Female

White

WIDOWED DIVORCED

Aug. 14, - 101

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House-wife

own home

11. BIRTHPLACE (County & State, or foreign country)

Somerset Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hiram Penrod

14. MOTHER'S MAIDEN NAME

Annie Boyts

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Laura T. Kelly

Bloomington, Md.

INTERVAL BETWEEN
ONSET AND DEATH

20 yrs

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4500

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Generalized arteriosclerosis

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES NO 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 1966 to....., 1967 that (I) (we) last
saw the deceased alive on....., 1967, and that death occurred at..... P.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Dr. James H. Wolverton Jr

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

22d. ADDRESS

Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 7/1/67 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
Bloomington Cemetery 23d. LOCATION (City, town or county) (State)
Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
Piedmont, W.Va.

25e. REC'D BY REGISTRAR JUL 6 1967

25b. REGISTRAR'S SIGNATURE
Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

after death. If any delay is
8. Give Pages 1, 2, and 3 to
along with form PM3. Page

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office at 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation or removal, and in any event within 72 hours after death.

TO FINERAI DIRECJOB: Base 3 should

TURKISH JOURNAL OF MEDICAL SCIENCES

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08216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08202

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Oakland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Memorial Hospital				d. STREET ADDRESS Rt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Truman		First Edward	Middle Uphold	Lost	4. DATE OF DEATH Month June Day 16th. Year 1967		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1929	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Minutes <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mason		10b. KIND OF BUSINESS OR INDUSTRY Masonry		11. BIRTHPLACE (State or foreign country) Oakland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jasper Uphold							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1951		17. INFORMANT Laura Uphold		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Allergic shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Multiple Bee Stings (b) Multiple Bee Stings DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: Stung by bees		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stung by bees					
20c. TIME OF INJURY Month, Day, Year Hour 11:30 AM Date 6-15-67 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) (Rural) Oakland Garrett Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> M.D.							
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		22. DATE SIGNED Oakland, Md. 6-16-67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Wolfe Cemetery		23d. LOCATION (City or Town) (County) (State) Garrett Co. Md.	
24. FUNERAL DIRECTOR Gerald D. Minnich				25. REGISTRAR'S SIGNATURE Charles Judge			
				26. DATE JUN 20 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08217

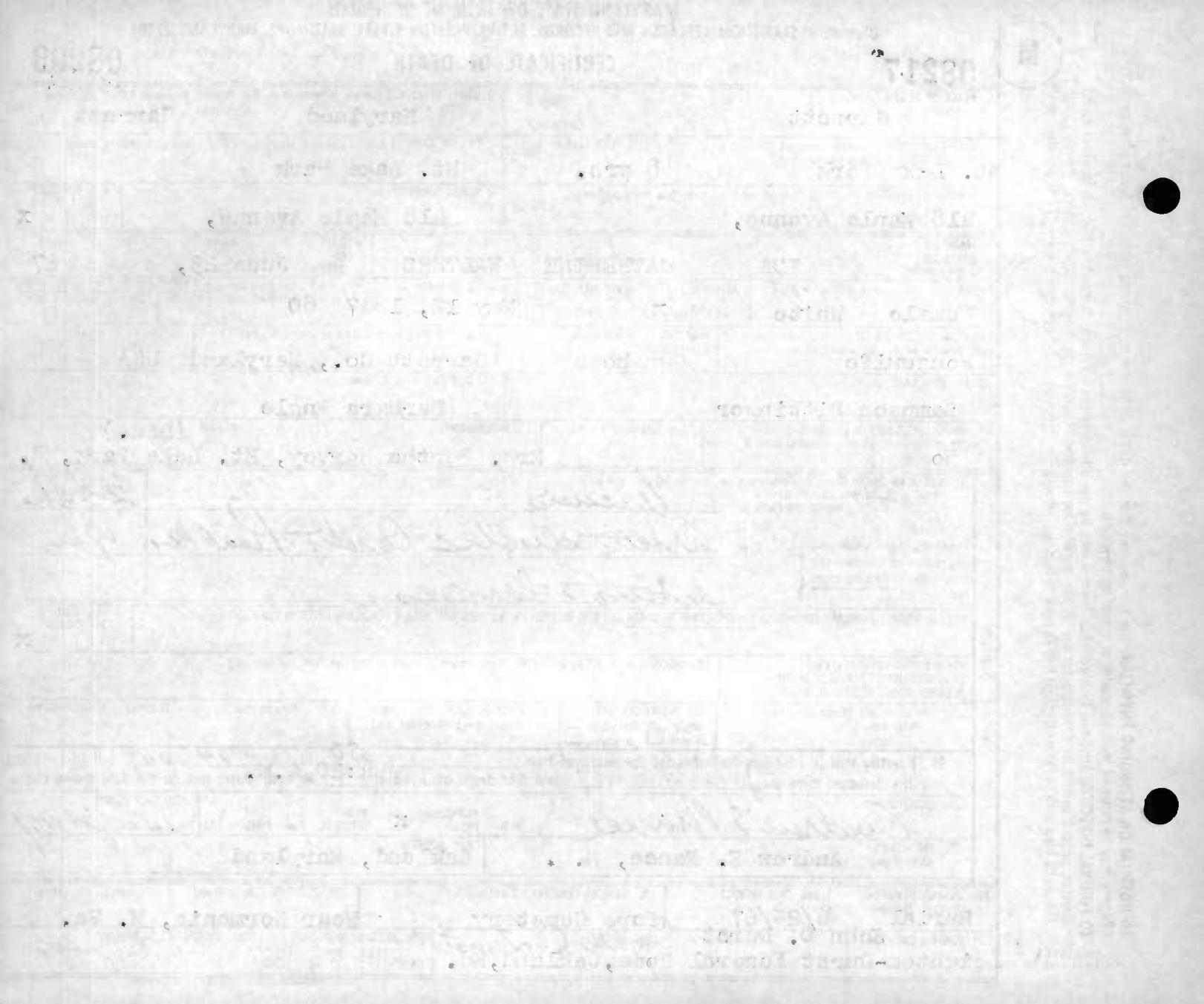
CERTIFICATE OF DEATH

08203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park			c. LENGTH OF STAY IN lb 8 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 418 Maple Avenue,			d. STREET ADDRESS 418 Maple Avenue,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First IDA	Middle CATHERINE	Lost WALTERS	4. DATE OF DEATH Month June 23,	Year 19 67
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 12, 1887	9. AGE (In years at birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		
11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sampson Bittinger			14. MOTHER'S MAIDEN NAME Barbara Engle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Bertha Harvey, Mt. Lake Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio - DUE TO Arteriosclerotic Cardio-Renal Dis- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. -years			INTERVAL BETWEEN DEATH AND DEATH 23 days		
DUE TO (b) Arteriosclerosis					
DUE TO (c) Arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10 , 1967, to June 24 , 1967, that (I) (we) last saw the deceased alive on June 10 , 1967, and that death occurred at 4:20 A.M. M., from causes and on the date stated above.		22b. DATE SIGNED June 24, 1967			
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.		22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/25/67		23c. NAME OF CEMETERY OR CREMATORIAL Pope Cemetery	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS John O. Durst		23d. LOCATION (City or Town) (County) (State) Near Gormanian, W. Va.	
VR A15 (4) 20 M 1/66		25a. REC'D BY REGISTRAR DATE JUN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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08218

CERTIFICATE OF DEATH

08205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3Hrs 30 Min.			c. LENGTH OF STAY IN lb Mt. Lake Park, Md.		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The Garrett Co. Memorial Hospital			d. STREET ADDRESS 911 Broadford Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Bertha			First Alice	Middle Weimer	4. DATE OF DEATH Month June Day 7 Year 1967
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widow	8. DATE OF BIRTH June 7, 1882	9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping			10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland	
13. FATHER'S NAME Jessie Weimer			14. MOTHER'S MAIDEN NAME Elizabeth Friend		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Records Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c) Generalized Arterosclerosis DUE TO INTERVAL BETWEEN ONSET AND DEATH days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 65 , to June 7 , 19 67 that (I) (we) last saw the deceased alive on Jun 6 , 19 67 , and that death occurred at 12:30 PM , fedthouses and on the date stated above.					
22a. SIGNATURE B. L. Grant					
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22b. DATE SIGNED 8 Jun 67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/67	23c. NAME OF CEMETERY OR CREMATORIAL Ferndale Cem.	23d. LOCATION (City or Town) (County) (State) Near Oakland, Md.	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR JUN 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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